UnityPoint Health

Parental Rights Verification Form

For your protection, and the person of whom you are requesting copies, we need verification from you that that *you* are entitled to receive the requested copies of your minor child's medical records.

I,_____, agree that
PRINT PARENTS' NAME

I am entitled to receive the medical records of my child

_____
PRINT CHILD'S NAME

I am verifying that *my* parental rights have not been terminated.

_____
PARENT'S SIGNATURE

_____
DATE